

APPOINTMENT OF REPRESENTATIVE**SECTION I. TO BE COMPLETED BY APPLICANT/BENEFICIARY**

Name	Case number <i>(optional)</i>	Date
------	-------------------------------	------

I appoint this individual _____ / _____
Name of individual *Name of organization*

Complete address _____ Telephone number _____
as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Medi-Cal benefits.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:


- submit requested verifications to the county welfare department;
- accompany me to any required face-to-face interview(s);
- obtain information from the county welfare department and from the State Department of Social Services, Disability Evaluation Division, regarding the status of my application;
- provide medical records and other information regarding my medical problems and limitations to the county welfare department or the State Department of Social Services, Disability Evaluation Division;
- accompany and assist me in the fair hearing process; and
- receive one copy of a specific notice of action from the county welfare department, at the request of the applicant/beneficiary.

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- complete and sign the Statement of Facts;
- attend and participate in any required face-to-face interview(s);
- sign MC 220 (Authorization for Release of Medical Information);
- provide all requested verifications before my Medi-Cal eligibility can be determined; and
- accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- choose anyone that I wish to be my authorized representative;
- revoke this appointment at any time by notifying my Eligibility Worker; and
- request a fair hearing at any time if I am not satisfied with an action taken by the county welfare department.

Applicant/Beneficiary's signature	Date
	
Address	


SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED. LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/BENEFICIARY BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/BENEFICIARIES BEHALF.**I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:**

- the applicant/beneficiary may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have no other power to act on behalf of the applicant/recipient, except as stated above;
- I may not act in lieu of the applicant/beneficiary; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/recipient.

I CERTIFY THAT:

- I have not been suspended or prohibited from practice before the Social Security Administration
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative; and
- I am known to be of good character.

This authorization expires upon a final eligibility determination and/or after the right to appeal has expired or at the conclusion of the fair hearing process.

Authorized representative's signature	Employed by	Date	Telephone number
			

COUNTY USE ONLY

Date verbal request to revoke received	Date written request to revoke received	Request received from:
EW name: _____		Telephone number: _____